HEALTHCONNECT Kansas

From the office of the Fiscal Agent

Kansas Medical Assistance Programs

Provider Line: **1-800-933-6593**
Consumer Line: **1-800-766-9012**

P.O. Box 3571, Topeka KS 66601-3571
Prior Authorization: 1-800-285-4978 or 785-274-5499
Prior Authorization Fax Lines: 1-800-913-2229 or 785-274-5956

Xolair
Prior Authorization Request Form

Consumer Name: _____

Consumer Medicaid ID #: _____ Date Of Birth: _____/_____/_____

Pharmacy Name: _____ Provider Medicaid ID#: _____

Phone Number: (_____)_____ Fax Number: (_____)_____

Drug Name: _____ NDC Requested: _____

- OR -

Prescribing Physicians Name: _____Provider Medicaid ID#: _____

Phone Number: (_____)_____ Fax Number: (_____)_____

Procedure Code: _____ # Units Requesting: _____

Compliance with all of the specific criteria listed below is a condition for payment for this drug by Kansas Medicaid.

All information must be provided and Kansas Medicaid may verify through further requested documentation and recipient's drug history will be reviewed.

1. Must be prescribed by one of the following specialists. Please circle one: Pulmonologist, Allergist, or Immunologist.

2. Detailed description of diagnosis/severity and age (must be ≥ 12 years old): _____

   _____

3. Date diagnosed: _____/_____/_____

4. List daily medications and dose prescribed for the treatment of this diagnosis:

   Drug/Dose: _____ Drug/Dose: _____

   Drug/Dose: _____ Drug/Dose: _____

5. Was a spacer for inhaled medications used? _____ If 'No' why not? _____

   _____

6. Compliant on daily medications for a minimum of 6 months prior to request? _____

   _____

(Xolair Prior Authorization Request Form continued)

7. Describe recipient's level physical activity: _____

_____

8. List frequency of:

Exacerbations – Number _____ Per _____; AND Nightly Symptoms – Number _____ Per _____

9. FEV_1 or PEF: _____% Date of Lab Testing: _____

10. Patients weight: _____kg; Baseline IgE Level: _____IU/ml; Xolair Dose: _____

Q 4 Weeks	Body Weight (kg)			
Pre-treatment Serum IgE (IU/mL)	30-60	> 60-70	> 70-90	> 90-150
> 30-100	150	150	150	300
> 100-200	300	300	300	
>200-300	300	DO NOT DOSE		

Q 2 Weeks	Body Weight (kg)			
Pre-treatment Serum IgE (IU/mL)	30-60	> 60-70	> 70-90	> 90-150
> 100-200				225
>200-300		225	225	300
>300-400	225	225	300	
> 400-500	300	300	375	
> 500-600	300	375	DO NOT DOSE	
> 600-700	375			

11. List perennial aeroallergen_____; Asthma reaction due to food or peanut allergy?

_____

The above format is to assist the physicians to provide medical documentation that Kansas Medicaid needs to review this request.

This information should come directly from the prescriber and not the pharmacy provider.

****Approval for a period of 6 months; request for extension must include a progress report regarding efficacy, adverse effects and compliance.**

****Please provide copies of medical documentation supporting the information above.**

Prescribing Physician's signature: _____Date: _____/_____/_____

Completed form should be faxed to the Prior Authorization Unit at 1-800-913-2229.
This form will be returned unprocessed if it is not completed in its entirety.
If a case has been started and the information requested is not received within 15 working days, the case will be denied.